		FOR OHF USE					

LL1

2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0043596

Facility Name: MAGNOLIA WOOD HEALTH CARE CENTER

Address: 900 NORTH MARKET STREET (Number) WATSEKA (City) 60970 (Zip Code)

County: IROQUOIS

Telephone Number: (815) 432-5261 **Fax #** (815) 432-5268

IDPA ID Number: 830320180003

Date of Initial License for Current Owners: 2/7/98

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: William H. Keys **Telephone Number:** (317) 208-2740

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2002 to 12/31/2002 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) Larry Bonds
(Title) President

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number MAGNOLIA WOOD HEALTH CARE CENTER # 0043596 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	13	Skilled (SNF)	13	4,745	1
2	0	Skilled Pediatric (SNF/PED)	0	0	2
3	63	Intermediate (ICF)	63	22,995	3
4	0	Intermediate/DD	0	0	4
5	0	Sheltered Care (SC)	0	0	5
6	0	ICF/DD 16 or Less	0	0	6
7	76	TOTALS	76	27,740	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	567	80	2,417	3,064	8
9	SNF/PED	0	0	0		9
10	ICF	8,229	3,641	0	11,870	10
11	ICF/DD	0	0	0		11
12	SC	0	0	0		12
13	DD 16 OR LESS	0	0	0		13
14	TOTALS	8,796	3,721	2,417	14,934	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 53.84%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A - None

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 2/7/1998

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 2/7/1998 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 13 and days of care provided 2,417

Medicare Intermediary TRAILBLAZER HEALTH ENTERPRISES, LLC

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2002 Fiscal Year: 12/31/2002

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number MAGNOLIA WOOD HEALTH CARE CEN # 0043596 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	98,693	3,490	3,960	106,143		106,143		106,143			1
2	Food Purchase		49,610		49,610		49,610	(1,662)	47,948			2
3	Housekeeping	81,069	3,770		84,839		84,839		84,839			3
4	Laundry	24,648	9,564		34,212		34,212		34,212			4
5	Heat and Other Utilities			53,773	53,773		53,773	174	53,947			5
6	Maintenance	32,069	7,102	15,346	54,517		54,517	7,799	62,316			6
7	Other (specify):*			4,437	4,437		4,437		4,437			7
8	**TOTAL General Services**	236,479	73,536	77,516	387,531		387,531	6,311	393,842			8
	B. Health Care and Programs											
9	Medical Director	22,853			22,853		22,853		22,853			9
10	Nursing and Medical Records	637,566	65,990	8,719	712,275		712,275		712,275			10
10a	Therapy	18,075	21,533	107,867	147,475		147,475		147,475			10a
11	Activities	32,257	1,409	2,708	36,374		36,374		36,374			11
12	Social Services	38,810		2,812	41,622		41,622		41,622			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	749,561	88,932	122,106	960,599		960,599		960,599			16
	C. General Administration											
17	Administrative	47,493		2,157	49,650		49,650	890	50,540			17
18	Directors Fees											18
19	Professional Services			12,934	12,934		12,934	14,391	27,325			19
20	Dues, Fees, Subscriptions & Promotions			9,148	9,148		9,148	110	9,258			20
21	Clerical & General Office Expenses	68,189	19,847	110,950	198,986		198,986	27,146	226,132			21
22	Employee Benefits & Payroll Taxes			173,739	173,739		173,739	4,304	178,043			22
23	Inservice Training & Education											23
24	Travel and Seminar			9,612	9,612		9,612	392	10,004			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			79,136	79,136		79,136		79,136			26
27	Other (specify):*											27
28	**TOTAL General Administration**	115,682	19,847	397,676	533,205		533,205	47,233	580,438			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,101,722	182,315	597,298	1,881,335		1,881,335	53,544	1,934,879			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number MAGNOLIA WOOD HEALTH CARE CENTER #0043596 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			48,617	48,617		48,617	175	48,792			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			423,881	423,881		423,881	(32,209)	391,672			32
33	Real Estate Taxes			26,169	26,169		26,169		26,169			33
34	Rent-Facility & Grounds							2,185	2,185			34
35	Rent-Equipment & Vehicles			16,337	16,337		16,337	176	16,513			35
36	Other (specify):*							122	122			36
37	TOTAL Ownership			515,004	515,004		515,004	(29,551)	485,453			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			3,041	3,041		3,041		3,041			38
39	Ancillary Service Centers		47,701		47,701		47,701		47,701			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			41,610	41,610		41,610		41,610			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		47,701	44,651	92,352		92,352		92,352			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,101,722	230,016	1,156,953	2,488,691		2,488,691	23,993	2,512,684			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number MAGNOLIA WOOD HEALTH CARE CENTER # 0043596 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,460)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(46)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(202)	2		13
14	Non-Care Related Interest	(32,965)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(2,035)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(2,724)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule (See page 5a)	(817)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (40,249)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	64,242	Var	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 64,242		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 23,993		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39			X			39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS
MAGNOLIA WOOD HEALTH CARE CENTER
ID# 0043596
Report Period Beginning: 1/1/2002
Ending: 12/31/2002

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4	Non-Patient Meals	(1,460)	2	4
5				5
6				6
7				7
8				8
9				9
10	Interest and Other Investment Income	(46)	32	10
11				11
12				12
13	Sales Tax	(202)	2	13
14	Non-Care Related Interest	(32,965)	32	14
15				15
16				16
17				17
18	Fines and Penalties	(2,035)	21	18
19				19
20				20
21				21
22	Special Legal Fees & Legal Retainers	(2,724)	19	22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31	Other non allowable expense	(597)	30	31
32	Vending revenue	(220)	21	32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(40,249)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number MAGNOLIA WOOD HEALTH CARE CENTER # 0043596 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,662)	0	0	0	0	0	0	0	0	0	0	(1,662)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	174	0	0	0	0	0	0	0	0	0	174	5
6	Maintenance	0	7,799	0	0	0	0	0	0	0	0	0	7,799	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(1,662)	7,973	0	0	0	0	0	0	0	0	0	6,311	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	890	0	0	0	0	0	0	0	0	0	890	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(2,724)	17,115	0	0	0	0	0	0	0	0	0	14,391	19
20	Fees, Subscriptions & Promotions	0	110	0	0	0	0	0	0	0	0	0	110	20
21	Clerical & General Office Expenses	(2,255)	29,401	0	0	0	0	0	0	0	0	0	27,146	21
22	Employee Benefits & Payroll Taxes	0	0	4,304	0	0	0	0	0	0	0	0	4,304	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	392	0	0	0	0	0	0	0	0	392	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(4,979)	47,516	4,696	0	0	0	0	0	0	0	0	47,233	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(6,641)	55,489	4,696	0	0	0	0	0	0	0	0	53,544	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number MAGNOLIA WOOD HEALTH CARE CENTER # 0043596 **Report Period Beginning:** 1/1/2002 **Ending:** 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(597)	0	772	0	0	0	0	0	0	0	0	175	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(33,011)	0	802	0	0	0	0	0	0	0	0	(32,209)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	2,185	0	0	0	0	0	0	0	0	2,185	34
35	Rent-Equipment & Vehicles	0	0	176	0	0	0	0	0	0	0	0	176	35
36	Other (specify):*	0	0	122	0	0	0	0	0	0	0	0	122	36
37	**TOTAL Ownership**	(33,608)	0	4,057	0	0	0	0	0	0	0	0	(29,551)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(40,249)	55,489	8,753	0	0	0	0	0	0	0	0	23,993	45

Facility Name & ID Number MAGNOLIA WOOD HEALTH CARE CENTER # 0043596 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See attached Organizational Structure Description						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	1	Dietary	$	Senior Living Properties, LLC	100.00%	$ 0	$	1
2	V	2	Food Purchase		Senior Living Properties, LLC	100.00%	0		2
3	V	3	Housekeeping		Senior Living Properties, LLC	100.00%	0		3
4	V	4	Laundry		Senior Living Properties, LLC	100.00%	0		4
5	V	5	Heat and Other Utilities		Senior Living Properties, LLC	100.00%	174	174	5
6	V	6	Maintenance		Senior Living Properties, LLC	100.00%	7,799	7,799	6
7	V	7	Waste Removal		Senior Living Properties, LLC	100.00%	0		7
8	V	10	Nursing & Medical Records		Senior Living Properties, LLC	100.00%	0		8
9	V	10a	Therapy		Senior Living Properties, LLC	100.00%	0		9
10	V	17	Administrative		Senior Living Properties, LLC	100.00%	890	890	10
11	V	19	Professional Services		Senior Living Properties, LLC	100.00%	17,115	17,115	11
12	V	20	Dues, Fees, Subscriptions & Promotions		Senior Living Properties, LLC	100.00%	110	110	12
13	V	21	Clerical & General Office Expenses		Senior Living Properties, LLC	100.00%	29,401	29,401	13
14	Total			$			$ 55,489	$ * 55,489	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number MAGNOLIA WOOD HEALTH CARE CENTER # 0043596 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	Employee Benefits & Payroll Taxes	$	Senior Living Properties, LLC	100.00%	$ 4,304	$ 4,304	15
16	V	24	Travel and Seminar		Senior Living Properties, LLC	100.00%	392	392	16
17	V	26	Insurance - Prop Liab Malpractice		Senior Living Properties, LLC	100.00%	0		17
18	V	30	Depreciation		Senior Living Properties, LLC	100.00%	772	772	18
19	V	32	Interest		Senior Living Properties, LLC	100.00%	802	802	19
20	V	33	Real Estate Taxes		Senior Living Properties, LLC	100.00%	0		20
21	V	34	Rent-Facility & Grounds		Senior Living Properties, LLC	100.00%	2,185	2,185	21
22	V	35	Rent-Equipment & Vehicles		Senior Living Properties, LLC	100.00%	176	176	22
23	V	36	Loss, Goodwill, & Depreciation		Senior Living Properties, LLC	100.00%	122	122	23
24	V	0	0				0		24
25	V	0	0				0		25
26	V	0	0				0		26
27	V	0	0				0		27
28	V	0	0				0		28
29	V	0	0				0		29
30	V	0	0				0		30
31	V	0	0				0		31
32	V	0	0				0		32
33	V	0	0				0		33
34	V		0				0		34
35	V		0				0		35
36	V		0				0		36
37	V		0				0		37
38	V		0				0		38
39	Total			$			$ 8,753	$ * 8,753	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number MAGNOLIA WOOD HEALTH CARE CENTER # 0043596 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number MAGNOLIA WOOD HEALTH CARE CENTER # 0043596 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number MAGNOLIA WOOD HEALTH CARE CENTER # 0043596 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number MAGNOLIA WOOD HEALTH CARE CENTER # 0043596 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number MAGNOLIA WOOD HEALTH CARE CENTER # 0043596 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number MAGNOLIA WOOD HEALTH CARE CENTER # 0043596 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number MAGNOLIA WOOD HEALTH CARE CENTER # 0043596 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number MAGNOLIA WOOD HEALTH CARE CENTER # 0043596 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number MAGNOLIA WOOD HEALTH CARE CEN # 0043596 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number MAGNOLIA WOOD HEALTH CARE CENTER # 0043596 Report Period Beginning: 1/1/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Senior Living Properties, LLC
Street Address: 12400 N. Meridian Street, Suite 180
City / State / Zip Code: Carmel, Indiana 46032
Phone Number: (317) 208-2740
Fax Number: (317) 575-2562

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	See attachment	See attachment	See attachment	$ 163	$	See attachme	$ 0	1
2	2	Food Purchase	See attachment	See attachment	See attachment	0		See attachment	0	2
3	3	Housekeeping	See attachment	See attachment	See attachment	0		See attachment	0	3
4	4	Laundry	See attachment	See attachment	See attachment	60		See attachment	0	4
5	5	Heat and Other Utilities	See attachment	See attachment	See attachment	18,884		See attachment	174	5
6	6	Maintenance	See attachment	See attachment	See attachment	741,985		See attachment	7,799	6
7	7	Waste Removal	See attachment	See attachment	See attachment	0		See attachment	0	7
8	10	Nursing & Medical Records	See attachment	See attachment	See attachment	300		See attachment	0	8
9	10a	Therapy	See attachment	See attachment	See attachment	0		See attachment	0	9
10	17	Administrative	See attachment	See attachment	See attachment	84,798		See attachment	890	10
11	19	Professional Services	See attachment	See attachment	See attachment	1,775,423		See attachment	17,115	11
12	20	Dues, Fees, Subscriptions & Prom	See attachment	See attachment	See attachment	76,549		See attachment	110	12
13	21	Clerical & General Office Expens	See attachment	See attachment	See attachment	3,248,251		See attachment	29,401	13
14	22	Employee Benefits & Payroll Taxe	See attachment	See attachment	See attachment	228,203		See attachment	4,304	14
15	24	Travel and Seminar	See attachment	See attachment	See attachment	821,540		See attachment	392	15
16	26	Insurance - Prop Liab Malpractic	See attachment	See attachment	See attachment	0		See attachment	0	16
17	30	Depreciation	See attachment	See attachment	See attachment	73,575		See attachment	772	17
18	32	Interest	See attachment	See attachment	See attachment	145,409		See attachment	802	18
19	33	Real Estate Taxes	See attachment	See attachment	See attachment	16		See attachment	0	19
20	34	Rent-Facility & Grounds	See attachment	See attachment	See attachment	208,088		See attachment	2,185	20
21	35	Rent-Equipment & Vehicles	See attachment	See attachment	See attachment	32,533		See attachment	176	21
22	36	Loss, Goodwill, & Depreciation	See attachment	See attachment	See attachment	12,011		See attachment	122	22
23	0	0				0				23
24	0	0				0				24
25	TOTALS					$ 7,467,788	$		$ 64,242	25

Facility Name & ID Number MAGNOLIA WOOD HEALTH CARE CENTER # 0043596 Report Period Beginning: 1/1/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number MAGNOLIA WOOD HEALTH CARE CENTER # 0043596 Report Period Beginning: 1/1/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number MAGNOLIA WOOD HEALTH CARE CENTER # 0043596 Report Period Beginning: 1/1/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number MAGNOLIA WOOD HEALTH CARE CENTER # 0043596 Report Period Beginning: 1/1/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number MAGNOLIA WOOD HEALTH CARE CENTER # 0043596 Report Period Beginning: 1/1/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number MAGNOLIA WOOD HEALTH CARE CENTER # 0043596 Report Period Beginning: 1/1/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number MAGNOLIA WOOD HEALTH CARE CENTER # 0043596 Report Period Beginning: 1/1/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
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15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number MAGNOLIA WOOD HEALTH CARE CENTER # 0043596 Report Period Beginning: 1/1/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
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17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number MAGNOLIA WOOD HEALTH CARE CENTER # 0043596 Report Period Beginning: 1/1/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
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17										17
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19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number MAGNOLIA WOOD HEALTH CARE CEN # 0043596 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	GMAC Comm Mort Corp		X	Acquisition	$27,730.00	2/6/98	$ 3,954,322	$ 4,465,290	2/1/08	0.0681	$ 310,804	1
2	Complete Care Services		X	Acquisition	$1,021.00	2/6/98	174,970	184,831	2/6/08	N/A - None	N/A - None	2
3	Manager Note		X	Acquisition	$1,021.00	2/6/98	174,970	184,831	2/6/08	N/A - None	N/A - None	3
4												4
5												5
	Working Capital											
6	Line of Credit		X	Working Capital	None	2/6/98	Various		Demand	Prime + 2%	30,806	6
7	Other Interest										50,107	7
8												8
9	TOTAL Facility Related				$29,772.00		$ 4,304,262	$ 4,834,952			$ 391,717	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 4,304,262	$ 4,834,952			$ 391,717	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number MAGNOLIA WOOD HEALTH CARE CENTER # 0043596 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2001 report.	$	26,170	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	26,170	2
3. Under or (over) accrual (line 2 minus line 1).	$		3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)	$	26,169	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	26,169	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1997	29,391	8
	1998	30,002	9
	1999	25,500	10
	2000	22,752	11
	2001	26,170	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME MAGNOLIA WOOD HEALTH CARE CENTER COUNTY IROQUOIS

FACILITY IDPH LICENSE NUMBER 0043596

CONTACT PERSON REGARDING THIS REPORT William H. Keys

TELEPHONE (317) 208-2740 FAX #: (317)581-9513

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	17-C-19-31-227-003	See Attached	$ 26,430.66	$ 26,430.66
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 26,430.66	$ 26,430.66

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

Facility Name & ID Number MAGNOLIA WOOD HEALTH CARE CENTER # 0043596 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 16,089 B. General Construction Type: Exterior BRICK Frame WOOD Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	98,881	1998	$ 21,462	1
2					2
3	TOTALS	98,881		$ 21,462	3

Facility Name & ID Number MAGNOLIA WOOD HEALTH CARE CENTER # 0043596 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	76		1998	1969	$ 805,098	$ 26,837	30	$ 26,837	$	$ 131,947	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	interior			1998	41	8	5	8		34	9
10	paint			1998	104	21	5	21		87	10
11	carpet admin-O			1998	360	72	5	72		306	11
12	install tile			1998	560	56	10	56		256	12
13	carpet admin-O			1998	895	179	5	179		761	13
14	painting labor			1998	1,386	277	5	277		1,155	14
15	painting labor			1998	1,500	300	5	300		1,275	15
16	steel door install			1998	1,804	90	20	90		390	16
17	alarm system			1998	2,581	258	10	258		1,118	17
18	install fire alarm			1998	2,873	287	10	287		1,197	18
19	painting labor			1998	2,893	579	5	579		2,363	19
20	tile & cov base			1998	5,593	280	20	280		1,166	20
21	signage			1998	464	46	10	46		212	21
22	land improvement (purchase price)			1998	8,956	597	15	597		2,935	22
23	paint-borders			1999	469	94	5	94		368	23
24	roof to cover patio			1999	3,071	307	10	307		1,203	24
25	paint trim			1999	524	105	5	105		411	25
26	painting labor			1999	304	61	5	61		233	26
27	install tile			1999	1,109	55	20	55		212	27
28	shutters			1999	600	40	15	40		153	28
29	nurses call battery backup			1999	1,177	118	10	118		442	29
30	light fixtures			1999	1,390	139	10	139		521	30
31	pave parking lot			1999	6,684	334	20	334		1,336	31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number MAGNOLIA WOOD HEALTH CARE CENTER # 0043596 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	water heater	2001	$ 2,464	$ 164	15	$ 164	$	$ 328	37
38	privacy leverset	2001	522	65	8	65		92	38
39	phone hook up in therapy room	2001	505	101	5	101		135	39
40	natural gas water heater	2001	2,585	259	10	259		259	40
41	motorized fire & smoke dampers	2002	1,125	37	10	37		37	41
42	4 fire dampers	2002	2,749	31	15	31		31	42
43	13 new smoke detectors	2002	1,980	33	10	33		33	43
44	steel smoke door	2002	1,762	20	15	20		20	44
45									45
46	land improvement (purchase price)	1998	(8,956)	(597)	15	(597)		(2,935)	46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63	(DON'T ENTER BELOW THIS LINE)								63
64	Total (This Page)								64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 855,172	$ 31,253		$ 31,253	$	$ 148,081	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MAGNOLIA WOOD HEALTH CARE CENTER # 0043596 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 855,172	$ 31,253		$ 31,253	$	$ 148,081	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 855,172	$ 31,253		$ 31,253	$	$ 148,081	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MAGNOLIA WOOD HEALTH CARE CENTER # 0043596 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 855,172	$ 31,253		$ 31,253	$	$ 148,081	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 855,172	$ 31,253		$ 31,253	$	$ 148,081	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MAGNOLIA WOOD HEALTH CARE CENTER # 0043596 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 855,172	$ 31,253		$ 31,253	$	$ 148,081	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 855,172	$ 31,253		$ 31,253	$	$ 148,081	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MAGNOLIA WOOD HEALTH CARE CENTER # 0043596 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 855,172	$ 31,253		$ 31,253	$	$ 148,081	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 855,172	$ 31,253		$ 31,253	$	$ 148,081	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MAGNOLIA WOOD HEALTH CARE CENTER # 0043596 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 855,172	$ 31,253		$ 31,253	$	$ 148,081	1
2									2
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5									5
6									6
7									7
8									8
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 855,172	$ 31,253		$ 31,253	$	$ 148,081	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MAGNOLIA WOOD HEALTH CARE CENTER # 0043596 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 855,172	$ 31,253		$ 31,253	$	$ 148,081	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 855,172	$ 31,253		$ 31,253	$	$ 148,081	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MAGNOLIA WOOD HEALTH CARE CENTER # 0043596 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 855,172	$ 31,253		$ 31,253	$	$ 148,081	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
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28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 855,172	$ 31,253		$ 31,253	$	$ 148,081	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MAGNOLIA WOOD HEALTH CARE CENTER # 0043596 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 855,172	$ 31,253		$ 31,253	$	$ 148,081	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 855,172	$ 31,253		$ 31,253	$	$ 148,081	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MAGNOLIA WOOD HEALTH CARE CENTER # 0043596 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 99,857	$ 16,655	$ 16,655	$	Various	$ 64,663	71
72	Current Year Purchases	2,687	112	112		Various	112	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 102,544	$ 16,767	$ 16,767	$		$ 64,775	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Vehicle - Van		2000	$ 10,500	$ 2,100	$ 2,100	$	5	$ 2,800	76
77										77
78										78
79										79
80	TOTALS			$ 10,500	$ 2,100	$ 2,100	$		$ 2,800	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 989,678	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 50,120	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 50,120	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 215,656	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	N/A			$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: [ ] YES [X] NO Terms: N/A *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ 16,513 Description: Central Supply - 11,803, Dietary - 539, Housekeeping - 200, Administrative - 3,795, Home Office - 176
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	N/A		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number MAGNOLIA WOOD HEALTH CARE CENTER # 0043596 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   [ ] YES
   [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a, 3	hrs	$	533	$ 36,960	$ 105	533	$ 37,065	1
2	Licensed Speech and Language Development Therapist	10a, 3	hrs		32	3,182	0	32	3,182	2
3	Licensed Recreational Therapist	10a, 3	hrs		0	0	21,303		21,303	3
4	Licensed Physical Therapist	10a, 3	hrs		965	67,726	124	965	67,850	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$	1,530	$ 107,868	$ 21,532	1,530	$ 129,400	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number MAGNOLIA WOOD HEALTH CARE CENTER **#** 0043596 **Report Period Beginning:** 1/1/2002 **Ending:** 12/31/2002

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2002 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 19,393	$	1
2	Cash-Patient Deposits	372		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	202,427		3
4	Supply Inventory (priced at)	11,285		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 233,477	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	21,462		13
14	Buildings, at Historical Cost	851,428		14
15	Leasehold Improvements, at Historical Cost	16,103		15
16	Equipment, at Historical Cost	109,731		16
17	Accumulated Depreciation (book methods)	(215,791)		17
18	Deferred Charges	2,577,777		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	541,681		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,902,391	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,135,868	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 373,478	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	12,430		28
29	Short-Term Notes Payable	1,042,631		29
30	Accrued Salaries Payable	108,607		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	25,710		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Other accrued expenses	10,559		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,573,415	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	4,736,796		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 4,736,796	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 6,310,211	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (2,174,343)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,135,868	$	48

***(See instructions.)**

Facility Name & ID Number MAGNOLIA WOOD HEALTH CARE CENTER # 0043596 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,460,515)	1
2	Restatements (describe):		2
3	**Restatements of Prior Year to allow rollforward**		3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,460,515)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(721,401)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **PRIOR YR ADJ - DEPREC**	7,573	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (713,828)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (2,174,343)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number MAGNOLIA WOOD HEALTH CARE CENTER # 0043596 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 1,594,988	1
2	Discounts and Allowances for all Levels	(312,244)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,282,744	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	220,344	6
7	Oxygen	45,418	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 265,762	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	158	13
14	Non-Patient Meals	1,460	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	88,240	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	45,749	19
20	Radiology and X-Ray		20
21	Other Medical Services	82,911	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 218,518	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	46	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 46	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	Vending	220	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 220	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 1,767,290	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	387,531	31
32	Health Care	960,599	32
33	General Administration	533,205	33
	B. Capital Expense		
34	Ownership	515,004	34
	C. Ancillary Expense		
35	Special Cost Centers	50,742	35
36	Provider Participation Fee	41,610	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,488,691	40
41	**Income before Income Taxes (line 30 minus line 40)****	(721,401)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (721,401)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number MAGNOLIA WOOD HEALTH CARE CENTER # 0043596 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,851	2,134	$ 48,600	$ 22.77	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,574	4,894	86,730	17.72	3
4	Licensed Practical Nurses	12,375	14,181	237,828	16.77	4
5	Nurse Aides & Orderlies	26,334	28,844	257,254	8.92	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,498	1,731	18,075	10.44	8
9	Activity Director	1,117	1,239	11,738	9.47	9
10	Activity Assistants	2,710	2,787	20,519	7.36	10
11	Social Service Workers	3,132	3,388	38,810	11.46	11
12	Dietician	1,981	2,126	28,872	13.58	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	8,911	9,512	69,821	7.34	15
16	Dishwashers					16
17	Maintenance Workers	2,455	2,495	32,069	12.85	17
18	Housekeepers	10,725	11,434	81,069	7.09	18
19	Laundry	3,416	3,696	24,648	6.67	19
20	Administrator	1,981	2,084	47,493	22.79	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,090	6,519	68,189	10.46	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director	933	1,148	22,853	19.91	27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	890	980	7,155	7.30	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	90,973	99,192	$ 1,101,723 *	$ 11.11	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	96	$ 3,960	1, 3	35
36	Medical Director	48	8,256	9, 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	48	370	10, 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	48	2,708	11, 3	44
45	Social Service Consultant	48	2,812	12, 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	288	$ 18,106		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number MAGNOLIA WOOD HEALTH CARE CENTER # 0043596 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Ron Corke	Admin.	0	$ 37,881
Keri Horn	Admin.	0	9,612
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 47,493

B. Administrative - Other

Description	Amount
Contract Svcs - Administrator	$ 2,157
TOTAL (agree to Schedule V, line 17, col. 3)	$ 2,157
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Legal Fees	Various	$ 2,724
Patient Litigation	Various	
Payroll Processing	Various	
Accounting	Various	6,500
EDP Services	Various	3,709
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 12,933

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 35,482
Unemployment Compensation Insurance	(2,980)
FICA Taxes	95,419
Employee Health Insurance	45,818
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	0
	0
	0
	0
Home Office Allocation	4,304
TOTAL (agree to Schedule V, line 22, col.8)	$ 178,043

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	7,925
Health Care Worker Background Check	
(Indicate # of checks performed 23)	
Dues & Subscriptions	1,223
Advertising & Public Relations	
Home Office Allocation	110
Less: Public Relations Expense	( )
Non-allowable advertising	
Yellow page advertising	
TOTAL (agree to Sch. V, line 20, col. 8)	$ 9,258

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	9,170
Seminar Expense	353
Business Meals	89
Home Office Allocation	392
Entertainment Expense	
TOTAL (agree to Sch. V, line 24, col. 8)	$ 10,004

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number MAGNOLIA WOOD HEALTH CARE CENTER # 0043596 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number MAGNOLIA WOOD HEALTH CARE CENTER # 0043596 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **1,506** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **41,610**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **1,460**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm?
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.